STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011906	A. BUILDING _____ B. WING _____	C 10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00118273. Complaint IN00118273 substantiated, no deficiencies related to the allegations are cited. Survey date: October 24, 2012 Facility number: 011906 Provider number: 155772 AIM number: 200912380 Survey team: Joyce Hofmann, RN Census bed type: SNF: 45 SNF/NF: 10 Residential: 33 Total: 88 Census payor type: Medicare: 34 Medicaid: 6 Other: 48 Total: 88 Sample: 3 Cobblestone Crossings Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00118273. Quality review completed 10/25/12 Cathy Emswiller RN	R 000		